Washington State

2002-2004 Comprehensive HIV Prevention Plan

2004 UPDATE

The Washington State HIV Prevention Planning Group dedicates this plan to Nancy P. Hall

Nancy worked tirelessly and with great vigor to ensure those infected and affected by HIV had a voice in the planning process. If HIV Prevention Community Planning were in Webster's Unabridged Dictionary, there would be a picture of Nancy next to the definition. She was able to bring people together regardless of their different socioeconomic background, race, ethnicity, and field of expertise to produce a viable HIV prevention plan for Washington State. Before Nancy ended her journey here with us, she was presented a plaque to show how much she was thought about. The plaque read as follows:

"In Recognition of the many years of dedicated services to prevent HIV and AIDS in Washington State and the ongoing efforts to improve the lives of our citizens who are infected and affected by HIV, we present you this humble token of our love and appreciation."

Presented on Behalf of:
Washington State HIV Prevention Community Planning Group (both current and former); HIV Prevention Regional Planning Groups (both current and former);
National Alliance of State and Territorial AIDS Directors; The Centers for Disease Control and Prevention; The AIDSNETs Council; Department of Health, Infectious Disease and Reproductive Health Staff; Department of Health, Community and Family Health, Assistant Secretary's Office; Department of Health, Office of the Secretary; Governor's Advisory Council on HIV/AIDS; Lifelong AIDS Alliance;
Pierce County AIDS Foundation; Spokane AIDS Network; People of Color Against AIDS Network; United Communities AIDS Network; University of Washington AIDS Education and Training Center

"You have made the hard work we do much easier by being a part of us and by who you are."

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INTRODUCTION

At it's May 22, 2003 meeting, the Washington State HIV Prevention Planning Group (SPG) voted to extend the timeframe of its current, multiyear Comprehensive HIV Prevention Plan from 2002-2003 to 2002-2004. Several critical factors affecting the planning process led to this decision:

1) From October 2002 onward, the SPG delayed initiating critical steps in the planning process, in anticipation that new Guidance for HIV Community Prevention Planning would be issued by CDC. The final guidance was not received until July 2003;
2) Nancy Hall, Washington State's longtime mentor, expert, and guiding force for HIV prevention planning, was diagnosed with terminal cancer in late 2002, and lost her battle against the disease in May 2003;
3) From July 2002 through February 2003, the SPG was actively engaged in research and study focused on HIV prevention strategies and interventions for its two highest priority populations, namely, MSM and IDU.

For these reasons, the SPG is presenting this 2004 Update to the Washington State 2002-2004 HIV Prevention Plan. Per guidance in CDC's Program Announcement for HIV Prevention Projects 2004-2008, this 2004 Update is a supplementary to the 2002-2004 Comprehensive HIV Prevention Plan for Washington State, and the SPG will attach this supplementary document to Washington State's 2004 CDC Cooperative Agreement for HIV Prevention Projects application. The original 2002-2003 HIV Prevention Plan and 2003 Plan Update have already been submitted to CDC.

In summary, the major activities and accomplishments of the SPG between August 2002 and August 2003 were:

1) Formation of expert committees to conduct research and provide reports to the SPG on additional examples of effective interventions for MSM and IDU's to supplement the existing table of "Prioritized Effective Interventions" for priority populations (see Attachments A and B).
2) Development of recommendations for state, regional, and local HIV prevention planning groups, as well as funding agencies and HIV prevention providers, on action steps to a) improve the quality and effectiveness of HIV prevention services and to b) enhance collaboration with related service providers. Two sets of recommendations were developed, one regarding IDU's and the other regarding MSM.

3) Initiating analysis of both the new CDC Guidance for HIV Prevention Community Planning, and the CDC's new initiative entitled "Advancing HIV Prevention: New Strategies for a Changing Epidemic". The SPG, and all its partners, are evaluating both documents and determining the impacts they present for HIV prevention policies, services, and planning in Washington State.
4) Addressing the primary directive for HIV prevention planning contained in CDC's new initiative by establishing HIV-infected individuals at the number one priority for CDC-supported HIV prevention efforts in Washington State (see Attachment C).
5) Completion of an SPG Policies and Procedures Manual addressing issues associated with membership and participation on the SPG not fully addressed in the SPG Charter (see Attachment D).
6) Completing an "HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers", under contract with the Washington Association of Community and Migrant Health Centers (Attachment E).

Most of the 7 Regional HIV Prevention Planning Groups (RPGs) develop Regional Comprehensive HIV Prevention Plans on multi-year cycles that do not coincide with each other or with the planning cycle of the SPG. All RPGs and the SPG have agreed that, in 2004, each jurisdiction will develop an HIV Prevention Plan for 2005-2008, based on the new HIV Prevention Community Planning guidance from the CDC, and to correspond to the time period of Washington State's Cooperative Agreement with CDC for HIV Prevention Projects. A major goal for the SPG, RPGs, and state Department of Health in the coming year is to train all members on the new CDC Guidance for HIV Prevention Community Planning to assure parity in understanding of the guidance among all members of all planning groups in Washington State.

As mentioned above, the SPG has already responded to new guidance from the CDC by establishing HIV-infected persons as the number one priority for CDC-supported HIV prevention efforts. Most of the planning groups have also responded to the planning guidance by utilizing the new Community Planning Membership Survey, Part 1, to collect demographic and other information about planning group members; and Part 2, to collect the opinions of planning groups members for assessing the implementation of HIV prevention community planning. These are Washington State's initial steps to address the goals, objectives, indicators, and attributes associated with successful HIV community prevention planning.

Note on the Organization of the 2004 Update

Although this 2004 Update is supplementary to plans developed according to the "old guidance", the authors have chosen to organize the content of this Update according to the goals and objectives included in the new HIV Prevention Community Planning Guidance. This approach will assist all planning partners, and other readers, to further their understanding of the new guidance and to see how Washington State fairs, currently, according to this new context.

New CDC Goal One:
Community planning supports broad-based community participation in HIV prevention planning.

This year, Washington State achieved partial implementation of the new CDC Community Planning Membership Survey, Parts I and II. Depending on the status of the planning process, some of the RPGs were able to collect data, using this new instrument, from the more than 80 regional planning group members. The SPG was able to collect data from 90% of its membership. Surveys were completed inconsistently by planning group members in this first attempt at statewide use, and for a variety of reasons. The data do not, therefore, give a complete and accurate portrayal of the membership and their characteristics. For this reason, the data were not analyzed to complete Part A of the Membership Survey Report. An important objective in future planning cycles will be the collection of more accurate and representative data from planning group members who are trained, and given more time, to complete the survey. Data for Part B of the Membership Survey are presented in this section, following Objective C.

Objective A: Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.

In its ongoing efforts to ensure broad-based participation in HIV prevention planning, the SPG recruited new members to address gaps that were identified in a July 2002 survey of planning group members. The Membership/PIR Committee of the SPG identified the need for 5 to 7 new, at-large members. The following priorities for new members were indicated: 1) representatives of statewide CBO's; 2) HIV-infected persons from communities of color, both male and female; 3) representation from faith communities; 4) representatives from mental health; and 5) representation from the Asian, Pacific Islander/Hawaiian, and American Indian populations. As of July 2003, the SPG received, reviewed, and approved six new applicants for membership. The addition of these new SPG members addresses most of the identified gaps, and membership has expanded from 26 to 32, the maximum number of members according to the SPG Charter. The Membership/PIR committee also addressed procedural and policy issues of concern to the SPG by proposing a new Policies and Procedures Manual, which was reviewed and approved by the SPG in May 2003 (see Attachment D).

All of the RPGs make annual, if not continual efforts, to improve and/or sustain PIR through recruitment of new members to fill identified gaps. While technically "open", most recruitment efforts are specifically targeted to secure new members who add diversity to the planning group composition. Success in recruitment is wide-ranging and greatly affected by factors such as geography, distance to travel for meetings, employment and meeting times, and community commitment. The RPGs report adding, on average, 4 new members in the past year. Membership on RPGs ranged from a high of 28 to a low of 11, with an average membership of 17. The ratio of women to men was nearly 1:1. All regions regret not having more members who are youth (only five group members, statewide, were recorded as being under 25 years of age).

The following Table 1 lists the RPG and SPG Health Department Co-chairs and Community Co-chairs by Regional AIDS Service Network (AIDSNET) in 2003.

TABLE 1: WASHINGTON STATE HIV PREVENTION PLANNING CO-CHAIRS FOR 2003

REGION 1: (Eastern) Spokane Regional Health District
Health Department Co-chair**:** **Barry Hilt**, Region 1 AIDSNET Coordinator
Community Co-chair**:** **Dale Briese**, Community Member
REGION 2: (Central) Yakima Health District
Health Department Co-chair: **Wendy Doescher**, Region 2 AIDSNET Coordinator
Community Co-chair**:** **Debra Severtson-Coffin**, Community Member
REGION 3: Snohomish Health District
Health Department Co-chair**:** **Ward Hinds, M.D**., Health Officer
Community Co-chair: **Rickey Burchyett**, Community Member
REGION 4: Public Health - Seattle & King Co.
Health Department Co-chair: **Bob Wood, M.D.**, AIDS Control Officer
Community Co-chair**:** **Sam Soriano**, Community Member
REGION 5: Tacoma-Pierce Co. Health Department
Health Department Co-chair: **Charles Fann,** TPC Health Department
Community Co-chair: **Alisa Soleberg**, Community Member/CBO
Kitsap County
Health Department Co-chair**:** **Lenore Morrey**, Bremerton-Kitsap Health District
Community Co-chair: **Michael Karpin**, Community Member
REGION 6: Clark County Health Department
Health Department Co-chair: **David Heal**, Region 6 AIDSNET Coordinator
Community Co-chair: **Janet Johnson**, Community Member
STATE PLANNING GROUP
Health Department Co-chair**:** **Jack Jourden**, Director, IDRH, WDOH
Community Co-chair: **James Minahan**, Community Member – Region 1
Community Vice-chair: **Sam Soriano**: Community Member – Region 4

Objective B: **Ensure that the CPGs' membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.**

The following Table 2 presents the results from Part I of the new CDC Community Planning Membership Survey, administered for the first time in Spring 2003 to the SPG and most RPGs.

TABLE 2: SPG and RPG MEMBERSHIP SURVEY RESULTS (PART I)

	SPG		REGIONS		STATE	EPIDEMIOLOGIC
			TOTALS		TOTAL	PROFILE DATA
AGE	**30**		**78**		**108**	
<19	0	0%	0	0%	0	<1%
20-24	0	0%	5	6%	5	
25-29	1	4%	8	10%	9	17% **(1)**
30-49	15	54%	36	46%	51	72%
50+	14	50%	29	37%	43	10%
GENDER	**30**		**78**		**108**	
Male	16	57%	37	47%	53	92%
Female	14	50%	39	50%	53	8%
Transgender	0	0%	2	3%	2	
SEXUAL ORIENTATION	**29**		**70**		**99**	
Heterosexual	14	52%	36	51%	50	6%
Gay Man	10	37%	22	31%	32	76% **(2)**
Bisexual Man	0	0%	2	3%	2	
Lesbian	5	19%	7	10%	12	
Bisexual Woman	0	0%	3	4%	3	
RACE	**30**		**77**		**107**	
AmerInd/AN	0	0%	7	9%	7	2%
Asian	1	4%	0	0%	1	2% **(3)**
Black/AfAm	5	18%	7	9%	12	11%
NatHaw/PacIs	0	0%	1	1%	1	NA **(4)**
White	24	86%	62	81%	86	90% **(5)**
ETHNICITY	**29**		**76**		**105**	
Hispanic/Latino	1	4%	10	13%	11	11%
Non-Hispanic/Latino	28	####	66	87%	94	89%
RISK POP YOU REPRESENT	**29**		**78**		**107**	
MSM	12	44%	29	37%	41	67%
MSM/IDU	3	11%	7	9%	10	10%
IDU	4	15%	10	13%	14	9%
Heterosexual	4	15%	15	19%	19	6%
Perinatal	0	0%	2	3%	2	<1%
General Population	6	22%	15	19%	21	5% **(6)**
GEOGRAPHIC LOCATION	**30**		**78**		**108**	
Rural	5	18%	8	10%	13	
Urban Non-Metro	13	46%	39	50%	52	
Urban Metro	12	43%	30	38%	42	
Other	0	0%	1	1%	1	

	SPG		REGIONAL TOTALS		STATE TOTAL	EPIDEMIOLOGIC PROFILE DATA
PRIMARY AREA EXPERTISE	**29**		**91**		**120**	
Epidemiologist	1		3		4	
Behavioral or Social Scientist	3		9		12	
Evaluation Researcher	0		5		5	
Intervention Specialist	4		28		32	
Health Planner	8		12		20	
Community Representative	9		33		42	
Other: Client	4		1		5	
Client Advocate			1		1	
Outreach			1		1	
Educator			2		2	
Project Coordination			1		1	
FAMILY/PARTNER LWHIV/AIDS	**28**		**30**		**58**	
Yes	14		14		28	
No	14		11		25	
Don't Know			5		5	
YOUR SEROSTATUS	**30**		**33**		**63**	
LWHIV/AIDS	7		9		16	
Not LWHIV/AIDS	14		20		34	
Affected by HIV/AIDS	9		3		12	
Don't Know	0		1		1	
ORG TYPE YOU REPRESENT	**30**		**93**		**123**	
Faith	2		4		6	
Minority CBO	3		7		10	
Non-Minority CBO	5		13		18	
Other Nonprofit	0		14		14	
Business and Labor	0		2		2	
Health Dep't: HIV/AIDS	10		20		30	
Health Dep't: STD	1		5		6	
Substance Abuse	0		2		2	
HIV Care and Social Services	2		5		7	
State/Local Education	1		1		2	
Mental Health	1		0		1	
Homeless Services	0		3		3	
Academic/Research	1		4		5	
Other: Client	4		5		9	
Community Representative			4		4	
Corrections			1		1	
Youth Development			3		3	
RECEIVE HIV$$ FROM HD	**30**		**23**		**53**	
Yes	12		4		16	
No	9		10		19	
N/A	9		9		18	

The following are notes for data from the Epidemiologic Profile listed in the tables above:

(1) Data is provided for the age range of 20 to 29;
(2) This figure is the percent of AIDS cases diagnosed among MSM and MSM/IDU;
(3) This figure includes Asians and Pacific Islanders;

(4) Data for the Native Hawaiian and Pacific Islander cases are included with Asians;
(5) Data for Whites includes Hispanics;
(6) General Public includes persons with no identified risk.

Not all of the RPGs utilized the new membership survey this year, nor did members complete the survey consistently. The data presented is, therefore, incomplete and did not allow for completion of Part A of the "HIV Prevention Community Planning Membership Survey Report" form. In the next planning cycle, all planning group members will be trained on the purpose and content of the survey instrument. In 2004, the survey will be consistently administered to the membership of the SPG and RPGs to collect more complete demographic and other data on the members of Washington State's planning groups.

The survey data presented does, however, provide representative data on planning group membership throughout the state. It illustrates that all planning groups include a diversity of populations in terms of race, ethnicity, gender, age and sexual orientation. The degree to which they reflect the specific diversity of populations most at risk for HIV infection is variable between planning groups. In general, females are over-represented on most planning groups, and young adults and youth are under-represented. The RPGs have had more success including American Native Populations and Hispanics than has the SPG. All groups have demonstrated success at including the primary populations at greatest risk for HIV infection, namely, MSM; MSM/IDU; IDU; and Heterosexuals at Risk, but more effort will be needed to include HIV-infected individuals in order to address CDC's new priorities.

A broad range of community and governmental organizations and expertise is represented on most planning groups. Health Department HIV/AIDS and STD programs represent more than 20% of RPG membership and approximately 30% of SPG membership.

New CDC program performance indicator E.1 asks states to report on "the proportion of populations *most at risk*, as documented in the epidemiologic profile, that have at least one CPG member that reflects the perspective of each population". The guidance suggests that up to ten such populations can be listed in the profile. Historically, Washington State has used the epidemiologic profile to identify highest priority behavioral risk categories, namely, MSM, IDU, and high risk Heterosexuals. This list will need to be expanded in the future to include additional subpopulations identified to be most at risk based on the epidemiologic profile. This expanded list will give all seven planning groups in the state another method for measuring their success at achieving the appropriate degree of representativeness for their jurisdiction.

Objective C: Foster a community planning process that encourages inclusion and parity among community planning members.

While representation on planning groups can be objectively measured, parity and inclusion are basic tenets of community planning that are much more challenging to measure. All planning groups in Washington State have established, and actively utilize, policies and procedures addressing P.I.R. and Conflict of Interest. All groups assure that meetings are held in ADA accessible facilities and strive to have meetings at times that are most convenient for the existing membership. Some groups are able to assist with travel costs, childcare costs, and in the case of the SPG, overnight accommodations to ensure statewide participation. Committee work is often accomplished by conference call, and conference lines are used to involve members in larger meetings, which they cannot attend in person. New member orientation, while not consistently provided in all planning groups, is recognized as indispensable to active participation. Special in-service presentations are often included in meeting agenda to address a variety of topics important to the planning process.

Opportunities for public input are also included in agenda, but special efforts are rarely made to actively solicit input from sectors of the community who aren't already participating in the process. The SPG agenda is routinely posted on the Washington State Department of Health HIV Prevention & Education Services website at www.doh.wa.gov/cfh/hiv.htm. It is also included in the quarterly *Washington State Responds to AIDS* newsletter which can also be found at this website. RPG meeting information is publicized in regional AIDSNET newsletters and mailings.

Power dynamics exist in all organizations, and HIV prevention community planning groups are no exception. These dynamics are usually unacknowledged in the course of regular business, and often result from seemingly benign factors, including unequal knowledge of or history with the planning process. Often participants don't know what they don't know, and rely on other more experienced or respected members of the group to make critical judgments that affect the planning process. Often these more experienced members are from funded CBO's and public health jurisdictions. It often doesn't emerge, until someone asks, that parity and inclusiveness of all members in the planning process has been compromised. And it is usually only after the important decisions have been made that such situations are realized. The SPG plans to address this issue in the coming year. In addition, dealing with conflict of interest, especially with regards to allocation decisions and PIR, will be addressed by the SPG.

The new planning guidance presents an opportunity to provide consistent training for all planning group members, statewide, on the methods and requirements of HIV prevention community planning. Consistency in training will assure that all members begin the new planning cycle with a parity of knowledge about the details of the process. A commitment by all planning groups to provide routine and consistent orientation for all new members will need to be established as well.

The issuance of new guidance also presents an opportunity to conduct an in-depth analysis of our accomplishments, in the last ten years, at achieving P.I.R. in the planning process, and to identify critical areas requiring improvements. The new membership survey is organized to collect meaningful qualitative data to determine how planning group members feel that parity, inclusion, and representativeness are being achieved.

The following Table 3 presents the results of Part II of the new CDC Community Planning Membership Survey, administered on September 25, 2003, at the final meeting of the SPG for this planning cycle. This part of the membership survey was completed by 19 members of the SPG present at the meeting following discussion of the DOH application to CDC for HIV prevention funding, and the decision by the SPG to concur, with one reservation, with the application.

TABLE 3: SPG MEMBERSHIP SURVEY RESULTS (PART II)

OBJECTIVE	AGREE	DIS AGREE	TOTAL	PERCENT AGREE
Objective A: *Implement an open recruitment process (outreach, nominations, and selection) for CPG membership.*	**132**	**0**	**132**	**100%**
Objective B: *Ensure that the CPGs' membership is representative of the diversity of populations most at risk for HIV infection and community characteristics in the jurisdiction, and includes key professional expertise and representation from key governmental and non-governmental agencies.*	**171**	**3**	**174**	**98%**
Objective C: *Foster a community planning process that encourages inclusion and parity among community planning members.*	**101**	**9**	**110**	**92%**
Objective C: *Foster a community planning process that encourages inclusion and parity among community planning members.*	**248**	**36**	**284**	**87%**
Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.	**69**	**5**	**74**	**93%**
Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.	**87**	**1**	**88**	**99%**
Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding. *Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.*	**45**	**3**	**48**	**94%**
TOTALS	**853**	**57**	**910**	**94%**

Table 3 presents survey data for the SPG only. In future funding cycles, the membership survey will be utilized by all of Washington State's planning groups to measure our success at meeting the goals and objectives established by the CDC for HIV Prevention Community Planning. The results shown above demonstrate a high level of agreement among current SPG members that the goals and objectives are being met. Even at this high level, however, DOH and the SPG have established a one-year target of increasing agreement to 95%, and a five-year target of 96% for the SPG. This survey data, along with data from Part I of the membership survey, will be carefully scrutinized by the Membership/PIR Committee, and by the full SPG, to identify improvements needed to meet the goals and objectives for HIV prevention planning in Washington State.

New CDC Goal Two
Community planning identifies priority HIV prevention needs (a set of priority target populations and interventions for each identified target population) in each jurisdiction.

Objective D: Carry out a logical, evidence-based process to determine the highest priority population-specific prevention needs in the jurisdiction.

Historically the SPG and DOH have developed guidance materials for conducting the required "steps' in prevention planning, as articulated in previous CDC guidance. Most recently the DOH Assessment Unit has produced "Prioritized Population Needs Assessment Guidance" including components for conducting surveys and focus groups. This year, an additional component (see Attachment F) on conducting key informant interviews has been developed and is currently under review by the DOH Institutional Review Board. Population-specific needs assessment data, gathered via this method, are used in conjunction with community resource inventories to characterize gaps in knowledge, attitudes, beliefs, and behavioral skills.

In this third year of a three-year planning cycle, the SPG focused its needs assessment activities on conducting an "HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers", under contract with the Washington Association of Community and Migrant Health Centers (see Attachment E). Additionally, in response to heighten awareness and new data on the re-emergence of STDs among MSM, the SPG requested and received reports on assessment and surveillance activities related to the MSM/STD outbreak from state and local public health officials (see Attachment A). The SPG held a two-day meeting in January to analyze and discuss the data, and to receive a report from its Effective Interventions Committee on additional examples of effective interventions for MSM.

The following needs assessments were completed by the regional planning bodies:

- ✓ Region 2 IDU
- ✓ Region 3 MSM-People of Color
- ✓ Region 4 Male to Female Transgender
- ✓ Region 4 African Immigrants
- ✓ Region 4 King County African Americans and Foreign-born Blacks
- ✓ Region 6 Female Methamphetamine Users

Objective E: Ensure that prioritized target populations are based on an epidemiologic profile and a community services assessment.

Every other year, the HIV Assessment Unit produces State and/or Regional HIV Epidemiologic Profiles to support the statewide HIV prevention planning and prioritization processes. The RPGs were last provided updated region-specific HIV/AIDS Epidemiologic Profiles in 2001. A finalized copy of the statewide HIV/AIDS Epidemiologic Profile Update for 2003 is included as Attachment G . For this year of the planning cycle, the Assessment Unit also focused on preparing data and reports to illustrate and describe the re-emergence of STDs among MSM in Washington State. These reports have assisted the SPG to understand the extent and distribution of STDs among MSM, and the incidence of coinfection with HIV. The reports and presentation contributed directly to the development of recommendations by the SPG regarding the prevention needs of MSM.

The most significant development affecting the priorities established by the state and regional planning groups was CDC's release of its new initiative entitled "Advancing HIV Prevention: New Strategies for a Changing Epidemic". The SPG received a presentation on the initiative shortly after its release and expressed its immediate concern that CDC will now pre-empt the prerogative of all planning groups to set there own priorities, and will require each planning group to establish HIV-infected person as the number one priority for HIV prevention efforts. Through careful analysis of its existing behaviorally-based priority risk categories, the SPG came to recognize that HIV-infected persons were already the highest priority *subpopulation* in each of its priority risk categories, and readily accepted the concept of elevating them to the status of number one priority for CDC-supported HIV prevention activities (see Attachment C).

A similar challenge faced the seven RPGs. Some had established HIV-infected persons as their number one priority in previous years, some have taken action to make it so this year, while others will make the change in next year's prioritization process. The priority target populations and subpopulations for 2004, both statewide and regionally, are presented in the following three tables.

TABLE 4: RANK ORDER OF BEHAVIORAL RISK CATEGORIES BY PLANNING GROUP

SPG	Region 1	Region	Region	Region 4	Region* 5-Kitsap	Region* 5-Pierce	Region 6
HIV+	HIV+	HIV+	HIV+	MSM (HIV+)	HIV+	HIV+	HIV+
MSM	MSM	MSM	MSM	HET	MSM	MSM	IDU
IDU	IDU	IDU	IDU	IDU	MSM/IDU	IDU	MSM
HET		HET	HET	Transgender	IDU	HET	HET
					HET		

*****Region 5 has 2 separate community planning groups (CPG) in Kitsap and Pierce Co.

Thus, with the SPG and six of seven RPGs having established HIV-infected persons as their number one priority, the requirement of the CDC has been met.

The Community Services Assessment, or CSA, is a "key product" defined in the new planning guidance that includes the following three previous "steps" in the planning process: 1) needs assessment, 2) resource inventory, and 3) gap analysis. As indicated in objective D above, an "HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers" was completed on behalf of the SPG, and six regional needs assessments were completed for selected target populations of importance to the RPGs. Gap analyses have subsequently been accomplished by some of the RPGs for some of the target populations, as well.

The health department is identified as the responsible party for production of the CSA for future planning cycles. In the coming year, the SPG will evaluate its existing guidance to the RPGs related to the three steps, and determine a method for revising and/or incorporating these documents into new guidance for conducting CSAs. The Washington State Department of Health, in coordination with the SPG, may need to assume a more active role in development of Community Services Assessments to characterize the needs and gaps in services that exist statewide in HIV prevention services for target populations, in particular HIV-infected persons. This will help the state, and the SPG, identify how to effectively address the strategies in the CDC's Advancing HIV Prevention Initiative.

TABLE 5: 2004 PRIORITIZED POPULATIONS AND SUBPOPULATIONS BY REGION

RANK	Region 1	Region	Region 3	Region 4	R 5 – Ki	Region 5 – Pierce	Region 6
#1	**HIV+ and/or their partners who…** Have multiple sex partners Engage in unprotected sex Share needles	**HIV+**	**HIV+**	**MSM** HIV+ HIV- and Unknown status Meth Injectors Non-gay ID Black Gay ID Black Gay and Non ID Latino	**MSM** Gay ID HIV+ <24 Non-gay ID	**HIV+**	**HIV +** People of Color Youth B/G/L/T/?
RANK	**Region 1**	**Region 2**		**Region 4**	**R 5 Ki**	**Pierce**	**R 6**
#2	**MSM and their partners who…** Have multiple sex partners Engage in unprotected sex Share needles	**MSM** Non-self ID <24	**MSM** Unprotected anal intercourse MSM/STD MSM/IDU	**Heterosexuals** Males and females with/at high risk for STD's Foreign-born Blacks HIV+ women and men and partners	**MSM/IDU** Meth users Heroin users	**MSM** African Amer MSM/IDU Latino Youth	**IDU** Partners of HIV+ Female Methamphetamine Users Homeless Injectors Incarcerated Injectors B/G/L/T/? Survival Sex

*BLGT? – bisexual, lesbian, gay, transgender and questioning people, usually associated with youth.

2004 PRIORITIZED POPULATIONS AND SUBPOPULATIONS BY REGION – CONT.

RANK	Region 1	Region 2	Region		Region 5 – Kitsa	Region 5 – Pierce	R
#3	**IDU and their partners who…** Have multiple sex partners Engage in unprotected sex Share needles	**IDU** Needle sharing	**IDU** People who share needles	**IDU** Homeless Youth and new injectors Latinos Female and Male street work (survival sex)	**IDU** Heroin User Meth user	**IDU** Share needles African Amer Latino/a	**MSM** HIV+ partner POC Non-ID MSM Survival Sex

RANK	Region 1	Region 2	Region 3		Region 5 – Kitsa	Region 5 – Pierc	Region 6
#4		**Heterosexual** Multiple sex partners Anal Sex	**Heterosexual** With STD Female with partner of unknown status	**Transgender** Male to Female	**Heterosexual** Partners of HIV+ Survival sex	**Heterosexual** Female partners of IDU or MSM/IDU	**Heterosexual** Female Methamphetamine Users Partners of IDU Partners of MSM Survival Sex

Objective F: Ensure that prevention activities/interventions for identified priority target populations are based on behavioral and social science, outcome effectiveness, and/or have been adequately tested with intended target populations for cultural appropriateness, relevance, and acceptability.

A major function of the SPG has been to identify and catalogue effective interventions, by intervention type, for each of its identified priority populations and provide this report to the RPGs to assist in their regional prioritization processes. The original 2002-2003 Comprehensive HIV Prevention Plan for Washington State includes the "Effective Intervention Matrix and Literature Review". The following Table 5, also from the original plan, lists the prioritized interventions for each prioritized population group that were established by the SPG in 2002. These priorities are unchanged and remain the priorities in this third year of the planning cycle.

As mentioned in Objective D, this year the SPG analyzed data related to the MSM/STD outbreak, held a two-day meeting in January to analyze and discuss the data, and used it to develop additional examples of effective interventions for MSM. The SPG reviewed statistical and anecdotal data regarding the increases in HIV transmission associated with unprotected sex occurring in bathhouses, public sex environments, and internet-facilitated transmission.

The SPG held another two-day meeting in February to analyze data and develop additional effective interventions for IDU. The interventions that were identified through this process are supplemental examples derived from the literature and do not effect the priorities as listed in Table 5.

Tables listing the RPG prioritized interventions for each prioritized population group are included with Objectives G and H. These tables also show the direct relationship between those interventions prioritized via the planning process, and those interventions that are funded with either CDC or state funds, or both.

TABLE 6: PRIORITIZED EFFECTIVE INTERVENTION BY BEHAVIORAL RISK CATEGORY

H				
		HC/PI	CTR/PCRS	PCM
1	Groups Individual Level		Targeted CTR PCRS "Person @risk"	PCM
2	Community Level Intervention (Communities of color)	Social Marketing Mass Media & Other Media		
3		Hotline/Clearinghouse		

M			
		HC/PI	CTR/PCRS
1	Community-level Interventions Group-level Interventions		CTR-high risk PCRS
2	Street/Community Outreach Individual-level Interventions	Social Marketing Mass Media & Other Media	
3		Hotline/Clearinghouse	

ID			
		HC/PI	CTR/PCRS
1	Needle Exchange Community-level Interventions		CTR –high risk PCRS
2	Individual-level Interventions Street/Community Outreach		
3	Group-level Interventions	Mass Media & Other Media Social Marketing Hotline/Clearinghouse	

HETEROSEXUAL - Urban			
		HC/PI	CTR/PCRS
1	Community-level Interventions Group-level Interventions Street/Community Outreach		CTR – high risk PCRS
2	Individual-level Interventions	Mass Media & Other Media Social Marketing	
3		Hotline/Clearinghouse	

HETEROSEXUAL - Rural			
	HERR	HC/PI	CTR/PCRS
1	Community-level Interventions Group-level Interventions	Mass Media & Other Media Social Marketing	CTR – high risk PCRS
2	Individual-level Interventions Street/Community Outreach		
3		Hotline/Clearinghouse	

CDC's Program Announcement 04012 for HIV Prevention Projects requires states to "ensure that PCRS is a high priority within the jurisdiction's HIV prevention activities and is so identified in the Comprehensive HIV Prevention Plan". The table shows that PCRS was identified a high priority intervention by the SPG in 2002, and remains so.

Even before CDC issued its Advancing HIV Prevention Initiative, prevention case management (PCM) was receiving increased emphasis and interest by planning groups and providers alike in Washington State. In October 2002, the Department of Health convened a group of providers from throughout the state to evaluate the existing CDC guidance on PCM and to begin producing our own state's guidance on PCM. It is expected that final guidance on PCM will be adopted by DOH by the end of 2003.

HIV Prevention programs continue to struggle with implementation of effective interventions. While some providers have chosen to implement "interventions in a box", others are attempting to address prevention needs with locally adapted interventions. The lack of interventions with evidence of effectiveness for rural areas is a major problem. One key task for all prevention planning partners in the coming year will be to better define what essential characteristics and components must be in place for an intervention to have evidence of demonstrated or probable outcome effectiveness, in the absence of having been shown to be effective in a research setting.

An outcome monitoring tool has been developed, and is currently being piloted by providers delivering individual and group level interventions (see Attachment H). Additional monitoring and evaluation requirements from CDC (PEMS) will require providers of HIV prevention interventions to establish new program procedures for data collection to demonstrate the effectiveness of their programs at reducing target behaviors among the intended audience.

The University of Washington, School of Social Work, HIV/AIDS Program Development and Evaluation Unit (HAPDEU) completed an outcome evaluation of the Friend To Friend Project in July, 2003 (see Attachment K). The Friend To Friend Project is based on the popular opinion leader model and is operated by HAPDEU. It has been one of the most broadly implemented interventions for MSM in Washington State.

New CDC Goal Three

Community planning ensures that HIV prevention resources target priority populations and interventions set forth in the Comprehensive HIV Prevention Plan.

Objective G: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and the Health Department Application for federal HIV prevention funding.

The key accountability measures of this objective are the Letters of Concurrence issued by the seven RPGs and the SPG. The RPGs determine whether or not the Regional AIDS Services Networks (AIDSNET) have developed a set of interventions, and a spending plan for CDC and State funds, that reflects the priorities established in their respective regional Comprehensive HIV Prevention Plan. The SPG determines whether or not the Washington State Department of Health's application for federal HIV prevention funding corresponds to the priorities established in the Washington State Comprehensive HIV Prevention Plan. The state and regional planning group Letters of Concurrence are included in Attachment I.

The following Table 6 (pages I through VII) provides detailed information, by region, of the state- and federally-funded interventions that are included in the health department's 2004 application for HIV prevention funding. The data presented in this table are extracted from the seven regional HIV Community Prevention Plans for 2004, and are included in Washington's web-based Statewide HIV Activity, Reporting, and Evaluation (SHARE) system. The table is organized as follows:

Column 1: Priority Population for HIV Prevention as specified in SPG and RPG plans.
Column 2: Priority Subpopulation, if any, as specified in the RPG plans.
Column 3: Recommended Interventions, as specified in the SPG or RPG plans.
Column 4: Actual Interventions Funded in the DOH application for federal funds.
Column 5: Source of Funding to support the intervention, state or federal.

Objective H: Demonstrate a direct relationship between the Comprehensive HIV Prevention Plan and funded interventions.

Table 6 presents information on the state- and federally-funded interventions that reflect the highest priorities of the SPG and the RPGs. This data does not present the full picture of all state-funded HIV interventions, however. In addition to those listed in Table 5, the following interventions targeting the general population, and other state-mandated activities, are supported with state funds:

- School-based Education and Technical Assistance for state-mandated HIV curricula
- Youth Peer Outreach Programs
- Legislatively required Education for healthcare providers, public employees, etc.
- Health Communication and Public Information for the general public
- HIV Counseling and Testing for the general public

Regional Plan Progress Reports

The following provides a brief report on the activities and accomplishments of the seven Regional Planning Groups (RPG) in the past year. In 2003, each planning group was at a different stage in planning, depending on which year of its planning cycle it was in. All RPGs and the SPG have agreed that, in 2004, each jurisdiction will develop an HIV Prevention Plan for 2005-2008, based on the new HIV Prevention Community Planning guidance from the CDC, and to correspond to the time period of Washington State's Cooperative Agreement with CDC for HIV Prevention Projects.

Region 1

Single Year 2004 Comprehensive HIV Prevention Plan

In 2003, Region 1 focused on evaluating the RPG's PIR Plan, Mission Statement, and Bylaws. The RPG also analyzed the new directives for prevention planning from the CDC, and initiated planning for a Comprehensive HIV Prevention Plan for 2005-2008. Region 1 had identified HIV+ individuals as its number one priority population in 2002 and did not need to reprioritize populations to address this new directive from the CDC. The RPG articulated its technical assistance needs for preparing a 2005-2008 plan, in accordance with the new CDC guidance on HIV prevention community planning.

Region 2

Third Year of a four year Comprehensive HIV Prevention Plan

In 2003, Region 2 conducted an IDU population needs assessment and gap analysis and is analyzing its current interventions targeted to IDU. The RPG reviewed and revised its PIR Plan, Bylaws, and Grievance Policy. Region 2 is carefully monitoring implementation of the "interventions in a box" that began in 2002. The committee identified HIV+ persons as its number one priority population as required by the CDC.

Region 3

Second Year of a three year Comprehensive HIV Prevention Plan

Region 3, conducted a needs assessment and gap analysis for men who have sex with men (primarily MSM of Color) and prioritized HIV+ persons as its new number one priority population. The committee reviewed its overall planning processes and began preparing for a new planning cycle to produce a 2005-2008 Comprehensive HIV Prevention Plan.

Region 4

Year One of a two year Comprehensive HIV Prevention Plan

Increasing and diversifying membership has been a focus for the RPG. Needs assessments conducted for four populations have led to improved efforts targeting African Americans, African immigrants, and Transgenders. Assessments are planned for the Latino community, and for MSM who attend bathhouses. Building bridges between care and prevention services is a current high priority for the RPG and its parent organization, the Seattle HIV/AIDS Planning Council.

Region 5 Pierce

Single Year 2004 Comprehensive HIV Prevention Plan

The RPG and the local Ryan White Care Consortium worked to improve collaboration and have established monthly prevention and care coordination meetings. The RPG held a team building retreat to focus on group dynamics, mission, organization, and timeline planning. The RPG thoroughly analyzed its technical assistance needs.

Region 5 Kitsap

Year Two of a two year Comprehensive HIV Prevention Plan

The Kitsap RPG conducted its first effort at producing a plan update independently from Pierce County. This attempt was partially successful. The RPG will evaluate this approach particularly in light of new guidance and increased accountability standards for planning from the CDC.

Region 6

Year Three of a three year Comprehensive HIV Prevention Plan

Region 6 reprioritized populations based on a new analysis of the Region 6 Epidemiologic Profile, and implemented the new CDC requirement to establish HIV+ individuals as priority number one. The region carried out a needs assessment focusing on female methamphetamine users and conducted a gap analysis on the same population. Regional staff oriented new members, as well as local health jurisdiction staff, on the CDC's new initiative. The region focused in the past year on ensuring that effective interventions are identified and implemented by funded agencies throughout the region.

RPG Technical Assistance Needs

Each RPG listed technical assistance needs in this year's plan or plan update. Many of the needs are the same as in previous years, as RPGs strive to implement the required processes of HIV prevention community planning. While guidance has been developed by the SPG to address most required processes, implementation remains challenging for the RPGs. CDC's new planning guidance, re-emphasizes the importance of these processes for validating priorities established and decisions made by planning groups. The Department of Health will organize its technical assistance and capacity building plans to address the on-going, and newly emerging, challenges of prevention planning. The technical assistance needs, and the number of RPGs identifying them, are listed below:

- ✓ **Target Population Needs Assessment (6)**
- ✓ **Gap Analysis (6)**
- ✓ **Cost Effectiveness/Analysis (5)**
- ✓ **Outcome Effectiveness (4)**
- ✓ **Effective Interventions for Rural Areas (3)**
- ✓ **Prioritizing special populations (2)**
- ✓ **Interpretation of Epi Data (2)**
- ✓ **PIR (2)**
- ✓ **Evaluation of the planning process (2)**
- ✓ **Evaluation of HIV prevention strategies (2)**
- ✓ **Group dynamics/conducting effective meetings (2)**
- ✓ **Interventions that meet the requirements of the CDC and SPG (1)**
- ✓ **Linking HIV prevention and care services (1)**

Implementing CDC's new *Guidance for HIV Prevention Community Planning* and *Advancing HIV Prevention Initiative*

The coming year of HIV prevention community planning will be focused on responding to the new requirements and expectations of the CDC for state HIV Prevention Projects and Community HIV Prevention Planning Groups. The redesigned guidance for 2004-2008, in conjunction with the Advancing HIV Prevention Initiative, will require the re-orientation of all planning groups to new federal standards, processes, and priorities for HIV prevention planning and programming. Educating planners, providers, and affected populations will be a significant undertaking. The SPG, RPGs, Department of Health, and the AIDSNETs will need to closely collaborate in the development of a detailed plan of action for ultimately producing new 2005-2008 Comprehensive HIV Prevention Plans for the state and the regions. Following are some of the issues and questions that will need to be address in the action plan.

- What new guidance will the SPG be required to produce for the RPGs for accomplishing the new requirements of the CDC, i.e. guidance on conducting Community Services Assessments (CSA)?

- To what extent will Washington State's HIV prevention resources be used for *primary prevention* interventions vs. interventions for HIV-infected persons?

- Which type(s) of interventions will be the most effective at reducing new HIV infections in Washington State by 50% over the next five years?

- How will HIV prevention services be integrated into care and treatment services?

- What is the appropriate role and use of HIV rapid testing in a variety of settings, both traditional and non-traditional?

An important implication of the new initiative is increased collaboration between care and prevention services. Clarifying the roles and expectations of each in the programs of the other will be essential and ongoing. DOH has established an internal HIV care and prevention working group to identify issues and opportunities for collaboration. DOH and the SPG are anxious for HRSA and the CDC to define their expectations for collaboration between CDC-funded and HRSA-funded programs. It is essential that HRSA respond to the new initiative.

LIST OF ATTACHMENTS

ATTACHMENT A
Examples of Effective Interventions for MSM
SPG Recommendations for MSM

ATTACHMENT B
Examples of Effective Interventions for IDU's
SPG Recommendations for IDU's

ATTACHMENT C
Prioritized Populations Transitions Table

ATTACHMENT D
SPG Policies and Procedures Manual

ATTACHMENT E
HIV/AIDS Knowledge and Prevention Needs Assessment of Migrant Seasonal Farm Workers

ATTACHMENT F
Prioritized Population Needs Assessment Key Informant Interview Protocol

ATTACHMENT G
Epidemiologic Profile 2003

ATTACHMENT H
Outcome Monitoring Tool

ATTACHMENT I
Letters of Concurrence

ATTACHMENT J
HAPDEU Outcome Evaluation